

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145678</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/26/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF SCHAUMBURG</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>675 SOUTH ROSELLE ROAD</b> <b>SCHAUMBURG, IL 60193</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 3 urosepsis and also recent onset of: Acute DVT (Left popliteal deep vein thrombosis) with PE (Pulmonary embolism).	F 309			
F9999	The resident transferred to a different facility after discharge from the hospital. FINAL OBSERVATIONS  LICENSURE VIOLATION:  300.610a) 300.1210d)1)2) 300.3220f) 300.3240a)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.  Section 300.1210 General Requirements for Nursing and Personal Care  d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	F9999			

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F9999	<p>Continued From page 4 seven-day-a-week basis:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These regulations were not met as evidenced by the following:</p> <p>Based on record review and interview, the facility failed to follow their abuse policy to prevent neglect and failed to correctly transcribe a physician order to continue an anti-coagulant medication and a cardiology consultation for 1 resident (R3), in the sample of 4 residents reviewed for anticoagulant medication regimen and consultation. By failing to correctly transcribe physician orders to continue an anti-coagulant</p>	F9999			

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F9999	<p>Continued From page 5</p> <p>medication and to order a cardiology consultation, this failure resulted in R3's decline in physical condition requiring emergency hospitalization for acute onset of DVT (Deep Vein Thrombosis) with PE (Pulmonary Embolism).</p> <p>Findings include:</p> <p>R3 is a 74 year old male with multiple medical diagnoses that includes Chronic A-Fib (Atrial Fibrillation), CHF (Congestive heart failure) and COPD (Chronic obstructive pulmonary disease). Recent hospital admission from 1/9/13 to 1/23/13, shows that R3 was admitted for acute respiratory failure due to COPD, and then was also found to have a Rectus sheath hematoma wherein his anticoagulant medication was temporarily held. R3 was restarted on the anticoagulant medication prior to discharge to the facility on 1/23/13. R3 has also hx (history) of embolic stroke approximately 2 years ago.</p> <p>R3 was admitted to the facility on 1/23/13 for pulmonary rehabilitation.</p> <p>R3 per hospital Discharge Medication Reconciliation Physician Orders on 1/23/13 under the Consultant physician's order column indicated the following:</p> <p>a) an anticoagulant medication to be administered twice daily b) Cardiology consult to be ordered for R3's anticoagulant medication management .</p> <p>On 2/21/13 at 10am, E2- (Director of Nursing_</p>	F9999			

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F9999	<p>Continued From page 6</p> <p>stated that the nurses made a physician transcription error regarding anticoagulation management for R3 during his admission to the facility.</p> <p>R3 was not given an anticoagulation medication, nor was a cardiology referral was done while the resident was in the facility from 1/23/13 to 2/8/13. E2 discussed their protocol on new admissions as follows:</p> <ol style="list-style-type: none"> <li>1. the admission nurse transcribed the admission orders</li> <li>2. the shift nursing supervisor and the on-coming shift charge nurse reviews the admission orders.</li> <li>3. the facility admitting physician is notified for approval of the admission orders.</li> <li>4. the admitting nurse fax approved orders to pharmacy.</li> </ol> <p>On 2/21/13 at 11am, E5 (oncoming shift charge nurse) stated that he can not recall R3's admission medication profile. E5 further stated that he was made aware that the admission nurse "missed" the anticoagulant medication orders when R3 had already transferred to the hospital.</p> <p>On 2/25/13 at 2pm , E4 (admitting nurse), E3 (shift nurse supervisor) both stated that "they missed " the anticoagulation management orders for R3 on 1/23/13.</p> <p>On 2/21/13 at 3pm, Z1(family member of R3) stated that R3 did not receive anticoagulant medication while at the facility. The anticoagulant medication was held in the hospital due to development of rectal sheath hematoma, but was restarted prior to discharge from the hospital. R3 has to be on anticoagulation medication to prevent another " stroke " as explained by the cardiologist.</p>	F9999			

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F9999	Continued From page 7  On 2/21/13 at 10:30am, Z2 and Z3 (Pharmacy consultants) both stated that the pharmacy did not receive orders for anticoagulation medication from the facility's faxed admission orders for R3 on 1/23/13.  On 2/21/13 at 1:50pm, Z4 (attending physician) of R3 in the facility stated that he was not made aware of any anticoagulation medication management for R3 during admission on 1/23/13. On 2/26/13 at 2:30pm, Z5's NP (Nurse Practitioner) stated that R3 has to be on long term anticoagulation medication..  On 2/8/13, R3 was admitted to the hospital for urosepsis and also recent onset of: Acute DVT (Left popliteal deep vein thrombosis) with PE (Pulmonary embolism).  Review of facility P/P (Policy and Procedure) for Abuse Prevention Program under: Option 5: Neglect is "a facility's failure to provide adequate medical care that is necessary to avoid physical harm."  <b>B</b>	F9999			